

114.2 DIVISION OF HEALTH CARE FINANCE AND POLICY

114.2 CMR 6.00 STANDARD PAYMENTS TO NURSING FACILITIES

3. If the Provider's 1999 Capital Payment is greater than or equal to \$17.29, and its Capital Cost per diem is greater than \$17.29, its 2000 Capital Payment will be the greater of \$17.29 or 90% of its Capital Cost per diem.
4. If the Provider's 1999 Capital Payment is greater than or equal to \$17.29, and its Capital Cost per diem is lower than \$17.29, its 2000 Capital Payment will be its Capital Cost per diem.
5. If a Provider relicenses beds in 2000 which were out of service, its 2000 Capital Payment will be the lower of \$17.29 or the facility's most recent billing rates for Fixed Costs and Equity or Use and Occupancy.

(d) Capital Payment Adjustment.

1. Qualifying Providers. The Division will include a Capital Payment Adjustment for Providers that meet the following criteria:

- a. the 1999 Capital Payment exceeds the Capital Cost per diem calculated under 114.2 CMR 6.05(2)(b)5;
- b. the difference between the 1999 Capital Payment and the Capital Cost per diem, multiplied by 1998 Medicaid patient days, exceeds \$100,000.

2. Determination of Adjustment. For qualifying Providers, the Division will calculate the Capital Payment Adjustment as follows:

- a. 1998 Capital per diem. The Division will calculate a capital per diem including 1998 long term interest, building insurance, real estate taxes, and equipment rental. Long Term Interest will be limited to the proportion of reported interest supported by allowable depreciable fixed assets as of the date the Provider obtained its long term financing. The Division and/or the Division of Medical Assistance may conduct audits to verify amounts reported in the cost reports. The divisor will be the greater of 96% of Constructed Bed Capacity times 365 or the Actual Utilization Rate in 1998.

2. Preliminary Capital Payment Adjustment. If the 1998 Capital per diem exceeds the Provider's 2000 Capital Payment as determined under 114.2 CMR 6.05(2)(b), the difference is the Preliminary Capital Adjustment.

3. Preliminary Payment Adjustment. For purposes of determining the Capital Payment Adjustment, the Division will apply a Preliminary Payment Adjustment to reflect the percentage change from the facility's weighted preliminary Payments and its weighted current payments.

(i) The Division will calculate preliminary payments for each facility, which are the sum of the Nursing and Other Operating Payments and the Capital Payment prior to the the Capital Payment Adjustment.

(ii) The Division will determine the percentage change from the facility's weighted preliminary payment and its weighted current payment. The Division will use the methodology set forth in 114.2 CMR 6.06(1)(b) to calculate the weighted payments.

(iii) If the percentage increase between a facility's 2000 weighted preliminary payment as calculated above and its 1999 weighted current payment is greater than 6%, the adjustment from its 1999 weighted current payment will be limited to 6%, resulting in a negative preliminary payment adjustment. If a facility's 2000 weighted preliminary payment is lower than the facility's 1999 weighted current payment, the facility's 2000 payments will equal its 1999 payments including the 1999 Add-on of \$0.76, resulting in a positive payment adjustment.

114.2 DIVISION OF HEALTH CARE FINANCE AND POLICY

114.2 CMR 6.00 STANDARD PAYMENTS TO NURSING FACILITIES

4. Capital Payment Adjustment.

- a. If the Provider's Preliminary Total Payment Adjustment is positive and exceeds the Preliminary Capital Payment Adjustment, the Final Capital Payment Adjustment is zero.
- b. If the Provider's Preliminary Payment Adjustment is positive but less than the Preliminary Capital Payment Adjustment, the Final Capital Payment Adjustment will equal the Preliminary Capital Payment Adjustment.
- c. The Capital Payment Adjustment is subject to the Total Payment Adjustment under 114.2 6.06(1)(b).

(e) Weighted Capital Payment. If a Provider's licensed beds fall into different Capital Payment methods, the Division will calculate the Capital Payment for each type of licensed beds. The Division will weight the capital payment based on the number of licensed beds associated with each type of method.

(3) Revised Capital Payment for Substantial Capital Expenditure.

(a) General Notification Requirements. All Providers must notify the Division when they open, add new beds, renovate or re-open beds. The notification must contain the Provider's name, address and VPN, date of bed change, type of change and description of project.

(b) Request for Revised Capital Payment. A Provider may request a revised Capital Payment for capital costs associated with the change or renovation of licensed beds pursuant to an approved Determination of Need.

1. For the Providers specified in 114.2 CMR 6.05(1)(a), the Division will certify a Capital Payment of \$17.29.

2. The Division will calculate a revised Capital Payment for the Providers specified below.

a. Facilities that may request a revised Capital Payment include:

- (i) New Facilities and newly-licensed beds which open pursuant to a Determination of Need approved on or before March 7, 1996;
- (ii) Replacement Facilities which open on or after February 1, 1998 pursuant to a Determination of Need approved on or before March 7, 1996;
- (iii) Facilities with Renovations made pursuant to a Determination of Need;
- (iv) Facilities with twelve bed additions associated with a Determination of Need approved on or before March 7, 1996; and
- (v) Facilities which requested and received an approved Determination of Need pursuant to the delegated review process in 1996 under Department of Public Health regulation 105 CMR 100.505(a)(4).

b. If a Provider listed in 114.2 CMR 6.05(3)(b)2 requests a revised Capital Payment to reflect a change in beds, it must submit the following:

- (i) a description of the project;
- (ii) a copy of the construction contract;
- (iii) copies of invoices and cancelled checks for construction costs;
- (iv) a copy of the Department's licensure notification associated with the new beds; and
- (v) a copy of the mortgage.

The Division may request further information it determines necessary to calculate a revised Capital Payment.

114.2 DIVISION OF HEALTH CARE FINANCE AND POLICY

114.2 CMR 6.00 STANDARD PAYMENTS TO NURSING FACILITIES

- c. The Division will certify a temporary Capital Payment of \$17.29 upon receipt of the notification of the change in beds, rate adjustment request, and required supporting documentation.
- d. In order to calculate the final revised Capital Payment, the Division will determine the amount of new allowable assets and apply the Financing Factor in 114.2 CMR 6.05(2)(b)2.
- e. For the following facilities, the final revised Capital Payment will be the greater of 90% of the amount calculated under 114.2 CMR 6.05(3)(b)2d or \$17.29
 - (i) New Facilities and newly-licensed beds which open pursuant to a Determination of Need approved on or before March 7, 1996;
 - (ii) Replacement Facilities which open on or after February 1, 1998 pursuant to a Determination of Need approved on or before March 7, 1996;
 - (iii) Facilities with Renovations made pursuant to a Determination of Need approved on or before March 7, 1996;
 - (iv) Facilities with twelve bed additions associated with a Determination of Need approved on or before March 7, 1996; and
 - (v) Facilities which requested and received an approved Determination of Need pursuant to the delegated review process in 1996 under Department of Public Health regulation 105 CMR 100.505(a)(4).
- f. For the following facilities, the revised Capital Payment will be the lower of the amount calculated under 114.2 CMR 6.05(3)(b)2d or \$17.29:
 - (i) facilities which renovate pursuant to a Determination of Need approved after March 7, 1996; and
 - (ii) facilities that implement a transferred Determination of Need approved before March 7, 1996 but did not file a Notice of Intent to Acquire the facility before March 7, 1996. This provision will not apply if the transfer occurred on or after February 1, 1998 and before May 30, 1998. If the transfer occurred during this period, the revised Capital Payment will be determined under 114.2 CMR 6.05(3)(b)2e.
- g. The effective date of the revised Capital Payment will be the date upon which the Provider submits the notification and all information and documentation required in 114.2 CMR 6.05(3).

6.06 Other Payment Provisions

(1) Transition Payments. Transition Payments are the sum of the Payments for Nursing, Other Operating Costs, and Capital, subject to the Total Payment Adjustment.

(a) Preliminary Payments. The Division will calculate preliminary payments for each facility, which are the sum of the Nursing and Other Operating Payments and the Capital Payment, including the Capital Payment Adjustment under 114.2 CMR 6.05(2)(d). For hospital-based nursing facilities, the preliminary payments are the sum of the Standard Payments for Nursing and Other Operating Costs and the Capital Payment of \$17.29 per day.

(b) Total Payment Adjustment. There is an additional adjustment to reflect the percentage change from the facility's 2000 weighted Preliminary Payments and its weighted current payments.

1. Weighted Current Payment. A facility's current payments are its most recently certified payments effective December 1, 1999 less the 1999 Add-on of \$0.76. The Division will

114.2 DIVISION OF HEALTH CARE FINANCE AND POLICY

114.2 CMR 6.00 STANDARD PAYMENTS TO NURSING FACILITIES

calculate the weighted 1999 current payment using third quarter 1999 case mix proportions. The "weighted current payment" is the sum of the products of each category's current payment by its corresponding case mix proportions.

2. Weighted Preliminary Payment. The Division will calculate the weighted Preliminary Payment using third quarter 1999 case mix proportions. The "weighted preliminary payment rate" is the sum of the products of each category's preliminary 2000 payment by its corresponding case mix proportions.

3 Determination of Total Payment Adjustment.

- a. If the percentage increase between a facility's 2000 weighted preliminary payment as calculated above and its 1999 weighted current payment is greater than 6%, the facility's payment adjustment from its 1999 weighted current payment will be limited to 6%.
- b. If a facility's 2000 weighted preliminary payment as calculated above is lower than the facility's 1999 weighted current payment, the facility's 2000 payments will equal its 1999 payments including the 1999 Add-on of \$0.76.
- c. The Total Payment Adjustment will not be recalculated as a result of revised Capital Payments for a substantial capital expenditure.

(c) Add-on for Certified Nursing Assistants. The Division will include an add-on for the purpose of funding increases in the salaries, benefits and hours of Certified Nursing Assistants. The add-on is not subject to the Total Payment Adjustment. Any Provider open in 1998 that failed to file a required 1998 cost report by December 31, 1999 will not be eligible for this add-on.

1. Calculation of the Add-on.

- a. For each Provider, the Division will determine the total reported 1998 Certified Nursing Assistant Salaries.
 1. If the Division used a short year 1998 cost report to calculate the Provider's 2000 rate, the Division will annualize the reported Certified Nursing Salaries for that Provider.
 2. If a Provider opened in 1999, the Division will calculate the add-on using 1998 median reported Certified Nursing Assistant Salaries.
- b. The Division will multiply the Provider's 1998 Certified Nursing Assistant Salary amount by the Provider's 1998 Medicaid Utilization as reported in the 1998 Cost Report. Medicaid Utilization is Total Reported Medicaid Days divided by Total Reported Patient Days.
- c. The Division will sum the amount determined in 114.2 CMR 6.06(1)(c)1b for all Providers.
- d. For each Provider, the Division will divide the amount determined in 114.2 CMR 6.06(1)(c)1b by the amount determined in 114.2 CMR 6.06(1)(c)1c.
- e. The Division will multiply the resulting percentage by \$20 million.
- f. The Division will divide the amount calculated above by the product of:
 1. current licensed bed capacity for the Rate Year times the days in the Rate Year, times
 2. reported 1998 Actual Utilization, times
 3. reported 1998 Medicaid Utilization.

This amount will be included as an add-on to each Provider's 2000 rate.

2. Nurses Aide Labor Cost Recovery. Providers must increase amounts spent for Certified Nursing Assistant Services by the revenue generated by the add-on. The Division will determine whether the Provider spent the revenue on Certified Nursing Assistant services at the end of the calendar year. If the Division determines that the

114.2 DIVISION OF HEALTH CARE FINANCE AND POLICY

114.2 CMR 6.00 STANDARD PAYMENTS TO NURSING FACILITIES

Provider has not spent all of the revenue for Certified Nursing Assistant services, the Division will notify the Division of Medical Assistance of the amount to recover from the provider. The Division will determine the amount to be recovered as follows:

- a. The Division will multiply the add-on by Rate Year 2000 Medicaid patient days to determine the Medicaid revenue generated by the add-on.
- b. The Division will compare the amounts reported in the 1999 and 2000 Cost Reports in the following accounts:

Certified Nursing Assistant Salaries	6051.1
Nursing Assistant Purchased Service	6052.3
Group Life Health Insurance	4426.9
Payroll Taxes	4408.2
Pensions	4336.4
Benefits Other	4340.4

For the insurance, payroll tax, pension, and other benefits accounts, the Division will allocate the reported amounts based on reported nurses aide salaries to total nursing salaries.

- c. If the total amount reported in 2000 does not exceed the amount reported in 1999 by at least the amount of revenue generated by the add-on, there will be a recovery of the difference.
 - d. The Division and/or the Division of Medical Assistance may conduct audits to verify amounts reported in the cost reports.
- (d) Supplemental Payment. The Division will include a supplemental payment of \$0.25 per day in the rates of all Providers that received a perfect score of 132 from the Department of Public Health's most recent Survey Performance Tool for Nursing Homes. This payment is not subject to the Total Payment Adjustment.

- (2) Retroactive Adjustments. The Division will retroactively adjust payments in the following situations:

(a) Facilities which did not file a 1998 Cost Report. If a facility operational in 1998 did not file the 1998 cost report, the payments will be the lower of its current payments or the standard payments. If the facility does not file a 1998 cost report by May 1, 2000, the facility's payments will be lowered by 5%. If the facility does not file a 1998 cost report by July 1, 2000, the Division may terminate the facility's payments. If the facility files a 1998 cost report, the Division will calculate amended 2000 payments using the facility's 1998 cost report. The amended payments will be effective on the first day of the month following the receipt of an acceptable cost report. If the facility demonstrates that it cannot complete a 1998 cost report, it will continue to be paid at its current payments or it may request that the Division use a different base year cost report to determine its payments.

(b) Amended Payments for Prior Years. The Division will amend 2000 payments to reflect 1997, 1998 and 1999 rates amended for the following reasons: offbase and lookback rates pursuant to 114.2 CMR 5.11, administrative adjustments pursuant to 114.2 CMR 5.12; amended rates pursuant to an administrative appeal; amended DON approvals for Maximum Capital Expenditures if the original Determination of Need was approved prior to March 7, 1996, or any further adjustments to reflect the results of any desk or field audits conducted by the Division or the Division of Medical Assistance.

(c) Mechanical Errors. The Division may adjust payments if it learns that there is a material error in the rate calculations.

114.2 DIVISION OF HEALTH CARE FINANCE AND POLICY

114.2 CMR 6.00 STANDARD PAYMENTS TO NURSING FACILITIES

(d) Errors in the Cost Reports. The Division may adjust payments if it learns that the Provider has made a material error in the cost report.

(3) Ancillary Costs. Unless a Provider participates in the Ancillary Pilot Program with the Division of Medical Assistance, or a Provider's payments include Ancillary Services pursuant to the regulations or written policy of the purchasing agency, the Provider must bill Ancillary Services directly to the purchaser in accordance with the purchaser's regulations or policies.

(4) Residential Care Beds. The Division will establish separate Nursing and Other Operating Costs payments for Residential Care Beds in a dually-licensed facility. The Division will determine the proportion of 1998 reported costs allocable to the rest home beds. It will exclude from the calculation reported costs for Ward Clerk, Utilization Review, Medical Records, and Advisory Physician. Allowable costs will be limited to the 2000 freestanding rest home ceiling established in 114.2 CMR 4.00. The facility's payment for Residential Care Beds will not exceed its 2000 Payment for Payment Group H Nursing Facility Residents, and the rate will not be lower than its certified 1999 payment for Residential Care Beds. The Residential Care Bed payment is not subject to the Total Payment Adjustment set forth in 114.2 CMR 6.06(1)(b).

(5) Reopened Beds Out of Service. Providers with licensed beds that were out of service prior to 1998 which reopen in 2000 will receive the lower of the Standard Payments or the most recent prior payments inflated to 2000 for Nursing and Other Operating Costs.

(6) Pediatric Nursing Homes. Payments to facilities licensed to provide pediatric nursing facility services will be determined using 1998 Reported Costs for Nursing and Other Operating Costs, excluding Administration and General Costs. Administration and General Costs will be based on 1998 costs subject to a cap of \$11.48. A pediatric nursing facility may apply to the Division for a payment adjustment for the otherwise unrecognized medical costs of residents over the age of 22 who were previously enrolled in the facility's Chapter 766 program. The Division will calculate an adjustment to include the reasonable costs for these services subject to approval by the Division of Medical Assistance.

(5) Payments for Innovative and Special Programs. The Division will include an allowance for costs and expenses to establish and maintain an innovative program for providing care to Publicly-Aided Residents if:

1. The Provider has received prior written approval from the Executive Office of Elder Affairs to establish and maintain a program; or
2. The Provider participates in a special program pursuant to a contract with the Division of Medical Assistance under which it has agreed to accept residents designated by that agency.

(6) Receiverships. The Division may adjust the rate of a receiver appointed under M.G.L. c. 111, s. 72N solely to reflect the reasonable costs, as determined by the Division and Division of Medical Assistance, associated with the court-approved closure of the facility.

6.07 Reporting Requirements

(1) Required Cost Reports

(a) Nursing Facility Cost Report. Each Provider must complete and file a Nursing Facility Cost Report each calendar year. The Nursing Facility Cost Report must contain the complete financial condition of the Provider, including all applicable management company, central office, and real estate expenses.

114.2 DIVISION OF HEALTH CARE FINANCE AND POLICY

114. 2 CMR 6.00 STANDARD PAYMENTS TO NURSING FACILITIES

(b) Realty Company Cost Report. A Provider that does not own the real property of the nursing facility and pays rent to an affiliated or non-affiliated realty trust or other business entity must file or cause to be filed a Realty Company Cost Report.

(c) Management Company Cost Report. A Provider must file a separate Management Company Cost Report for each entity for which it reports management or central office expenses related to the care of Massachusetts publicly-aided residents. If the Provider identifies such costs, the Provider must certify that costs are reasonable and necessary for the care of Publicly-Aided Residents in Massachusetts.

(2) General Cost Reporting Requirements

(a) Accrual Method. Providers must complete all required reports using the accrual method of accounting.

(b) Documentation of Reported Costs. Providers must maintain accurate, detailed and original financial records to substantiate reported costs for a period of at least five years following the submission of required reports or until the final resolution of any appeal of a rate for the period covered by the report, whichever is later. Providers must maintain complete documentation of all of the financial transactions and census activity of the Provider and affiliated entities including, but not limited to, the books, invoices, bank statements, canceled checks, payroll records, governmental filings, and any other records necessary to document the Provider's reported costs. Providers must be able to document expenses relating to affiliated entities for which it has identified costs related to the care of Massachusetts publicly-aided residents whether or not they are Related Parties.

(c) Fixed Asset Ledger. Providers must maintain a fixed asset ledger which clearly identifies each asset for which expenses are reported, including location, date of purchase, cost, salvage value, accumulated depreciation, and the disposition of sold, lost or fully depreciated assets.

(d) Job Descriptions and Time Records. Providers and management companies must maintain written job descriptions including qualifications, duties, responsibilities, and time records such as time cards for all positions which the Provider identifies as related to the care of Massachusetts publicly-aided residents. Facilities organized as sole proprietors or partnerships in which the sole proprietor or partner functions as administrator with no reported administrator salary or benefits must maintain documentation to support the provision of administrator services by the sole proprietor or partner.

(e) Other Cost Reporting Requirements.

1. Administrative Costs. The following expenses must be reported as administrative:

- a. All compensation, including payroll taxes and benefits, for the positions of administrator, assistant administrator, administrator-in-training, business manager, secretarial and clerical staff, bookkeeping staff, and all staff or consultants whose duties are primarily administrative rather than directly related to the provision of on-site care to residents or to the on-site physical upkeep of the Nursing Facility;
- b. Expenses related to tasks performed by persons at a management level above that of an on-site Provider department head, which are associated with monitoring, supervising, and/or directing services provided to residents in a Nursing Facility as well as legal, accounting, financial and managerial services or advice including computer services and payroll processing; and
- c. Expenses related to policy-making, planning and decision-making activities necessary for the general and Long-Term management of the affairs of a Nursing Facility, including but not limited to the following: the financial management of the Provider, including the cost of financial accounting and management advisory consultants, the establishment of personnel policies, the planning of resident

114.2 DIVISION OF HEALTH CARE FINANCE AND POLICY

114. 2 CMR 6.00 STANDARD PAYMENTS TO NURSING FACILITIES

admission policies and the planning of the expansion and financing of the Provider.

d. providers must report the cost of administrative personnel to the appropriate account. The cost of administrative personnel includes all expenses, fees, payroll taxes, fringe benefits, salaries or other compensation.

e. Providers may allocate administrative costs among two or more accounts. The Provider must maintain specific and detailed time records to support the allocation.

2. Draw Accounts. Providers may not report or claim proprietorship or partnership drawings as salary expense.

3. Expenses which Generate Income. Providers must identify the expense accounts which generate income.

4. Fixed Costs.

a. Additions. If the square footage of the Building is enlarged, Providers must report all additions and renovations as Building Additions.

b. Allocation. Providers must allocate all fixed costs, except Equipment, on the basis of square footage. A Provider may elect to specifically identify Equipment related to the Nursing Facility. The Provider must document each piece of Equipment in the fixed asset ledger. If a Provider elects not to identify Equipment, it must allocate Equipment on the basis of square footage.

c. Replacement of Beds. If a Provider undertakes construction to replace beds, it must write off the fixed assets which are no longer used to provide care to Publicly-Aided Residents and may not identify associated expenses as related to the care of Massachusetts publicly-aided residents.

d. Fully Depreciated Assets. Providers must separately identify fully depreciated assets. Providers must report the costs of fully depreciated assets and related accumulated depreciation on all Cost Reports unless they have removed such costs and accumulated depreciation from the Provider's books and records. Providers must attach a schedule of the cost of the retired Equipment, accumulated depreciation, and the accounting entries on the books and records of the Provider to the Cost Report when Equipment is retired.

e. Providers must report all expenditures for major repair projects whose useful life is greater than one year, including, but not limited to, wallpapering and painting as Improvements. Providers may not report such expenditures as prepaid expenses.

5. Laundry Expense. Providers must separately identify the expense associated with laundry services for which non-Publicly-Aided Residents are billed. Providers must identify such expense as non-related to Medicaid patient care.

6. Mortgage Acquisition Costs. Providers must classify Mortgage Acquisition Costs as Other Assets. Providers may not add Mortgage Acquisition Costs to fixed asset accounts.

7. Nursing Costs. The costs must be associated with direct resident care personnel and be required to meet federal and state laws.

8. Related Parties. Providers must disclose salary expense paid to a Related Party and must identify all goods and services purchased from a Related Party. If a Provider purchases goods and services from a Related Party, it must disclose the Related Party's cost of the goods and services.

(f) Special Cost Reporting Requirements.

1. Facilities in which other programs are operated. If a Provider operates an adult day health program, an assisted living program, or provides outpatient services, the Provider

114.2 DIVISION OF HEALTH CARE FINANCE AND POLICY

114. 2 CMR 6.00 STANDARD PAYMENTS TO NURSING FACILITIES

may not identify expenses of such programs as related to the care of Massachusetts publicly-aided Residents.

- a. If the Provider converts a portion of the Provider to another program, the Provider must identify the existing Equipment no longer used in Nursing Provider operations and remove such Equipment from the Nursing Provider records.
- b. The Provider must identify the total square footage of the existing Building, the square footage as associated with the program, and the Equipment associated with the program.
- c. The Provider must allocate all shared costs, including shared capital costs, using a well-documented and generally accepted allocation method. The Provider must directly assign to the program any additional capital expenditures associated with the program.

2. Hospital-Based Nursing Facilities. A Hospital-Based Nursing Provider must file Cost Reports on a fiscal year basis consistent with the fiscal year used in the DHCFP-403 Hospital Cost Report. The Provider must:

- a. identify the existing Building and Improvement costs associated with the Nursing Provider. The Provider must allocate such costs on a square footage basis.
- b. report major moveable Equipment and fixed Equipment in a manner consistent with the Hospital Cost Report. In addition, the Provider must classify fixed Equipment as either Building Improvements or Equipment in accordance with the definitions contained in 114.2 CMR 6.02. The Provider may elect to report major moveable and fixed Equipment by one of two methods:
 1. A Provider may elect to specifically identify the major moveable and fixed Equipment directly related to the care of Publicly-Aided Residents in the Nursing Provider. The Provider must maintain complete documentation in a fixed asset ledger, which clearly identifies each piece of Equipment and its cost, date of purchase, and accumulated depreciation. The Provider must submit this documentation to the Division with its first Notification of Change in Beds.
 2. If the Provider elects not to identify specifically each item of major moveable and fixed Equipment, the Division will allocate fixed Equipment on a square footage basis.
- c. The Provider must report additional capital expenditures directly related to the establishment of the Nursing Provider within the hospital as Additions. The Division will allocate capital expenditures which relate to the total plant on a square footage basis.
- d. The Provider must use direct costing whenever possible to obtain operating expenses associated with the Nursing Provider. The Provider must allocate all costs shared by the hospital and the Nursing Provider using the statistics specified in the Hospital Cost Report instructions. The Provider must disclose all analysis, allocations and statistics utilized in preparing the Nursing Provider Cost Report.

(2) General Cost Principles. In order to report a cost as related to Medicaid patient care, a cost must satisfy the following criteria:

- (a) The cost must be ordinary, necessary and directly related to the care of Publicly-Aided Residents;
- (b) The cost must be for goods or services actually provided in the nursing facility; and
- (c) The cost must be reasonable; and

114.2 DIVISION OF HEALTH CARE FINANCE AND POLICY

114. 2 CMR 6.00 STANDARD PAYMENTS TO NURSING FACILITIES

(d) The cost must actually be paid by the Provider. Costs which are not considered related to the care of Massachusetts publicly-aided Residents include, but are not limited to: costs which are discharged in bankruptcy; costs which are forgiven; costs which are converted to a promissory note; and accruals of self-insured costs which are based on actuarial estimates;

(e) A provider may not report the following costs as related to the care of Massachusetts publicly-aided Residents:

1. Bad debts, refunds, charity and courtesy allowances and contractual adjustments to the Commonwealth and other third parties;
2. Federal and state income taxes, except the non-income related portion of the Massachusetts Corporate Excise Tax;
3. Expenses that are not directly related to the provision of resident care including, but not limited to, expenses related to other business activities and fund raising, gift shop expenses, research expenses, rental expense for space not required by the Department and expenditure of funds received under federal grants for compensation paid for training personnel and expenses related to grants of contracts for special projects;
4. Compensation and fringe benefits of residents on a Provider's payroll;
5. Penalties and interest, incurred because of late payment of loans or other indebtedness, late filing of federal and state tax returns, or from late payment of municipal taxes;
6. Any increase in compensation or fringe benefits granted as an unfair labor practice after a final adjudication by the court of last resort;
7. Expenses for Purchased Service Nursing services purchased from temporary nursing agencies that are not registered with the Department under regulation 105 CMR 157.000;
8. Any expense or amortization of a capitalized cost which relates to costs or expenses incurred prior to the opening of the facility;
9. All legal expenses; and those accounting expenses and filing fees associated with any appeal process.

(5) Filing Deadlines.

(a) General. Except as provided below, Providers must file required Cost Reports for the calendar year by 5:00 P.M. of April 1 of the following calendar year. If April 1 falls on a weekend or holiday, the reports are due by 5:00 P.M. of the following business day.

1. Change of Ownership. The transferor must file Cost Reports within 60 days after a Change of Ownership. The Division will notify the Division of Medical Assistance if required reports are not timely filed for appropriate action by that agency.
2. New Facilities and Facilities with Major Additions. New Facilities and facilities with Major Additions that become operational during the Rate Year must file year end Cost Reports within 60 days after the close of the first two calendar years of operation.
3. Hospital-Based Nursing Facilities. Hospital-Based Nursing Facilities must file Cost Reports no later than 90 days after the close of the hospital's fiscal year.
4. Termination of Provider Contract. If a Provider contract between the Provider and the Division of Medical Assistance is terminated, the Provider must file Cost Reports covering the current reporting period or portion thereof covered by the contract within 60 days of termination.
5. Appointment of a Resident Protector Receiver. If a receiver is appointed pursuant to M.G.L. c. 111, s. 72N, the Provider must file Cost Reports for the current reporting period or portion thereof, within 60 of the receiver's appointment.

114.2 DIVISION OF HEALTH CARE FINANCE AND POLICY

114.2 CMR 6.00 STANDARD PAYMENTS TO NURSING FACILITIES

(b) Extension of Filing Date. The Director of the ACE Group may grant a request for an extension of the filing due date for a maximum of 45 calendar days. In order to receive an extension, the Provider must:

1. submit the request itself, and not by agent or other representative;
2. demonstrate exceptional circumstances which prevent the Provider from meeting the deadline; and
3. file the request no later than 30 calendar days before the due date.

(6) Incomplete Submissions. If the Cost Reports are incomplete, the Division will notify the Provider in writing within 120 days of receipt. The Division will specify the additional information which the Provider must submit to complete the Cost Reports. The Provider must file the required information within 25 days of the date of notification or by April 1 of the year the Cost Reports are filed, whichever is later. If the Division fails to notify the Provider within the 120-day period, the Cost Reports will be considered complete and will be deemed to be filed on the date of receipt.

(7) Audits. The Division and the Division of Medical Assistance may conduct Desk Audits or Field Audits to ensure accuracy and consistency in reporting. Providers must submit additional data and documentation relating to the cost report, the operations of the Provider and any Related Party as requested during a Desk or Field Audit even if the Division has accepted the Provider's Cost Reports.

(8) Penalties for Late Filing of Cost Reports.

(a) If a Provider does not file the required Cost Reports by the due date, the Division will reduce the Provider's rates for current services by 5% on the day following the date the submission is due and 5% for each month of non-compliance thereafter. The reduction accrues cumulatively such that the rate reduction equals 5% for the first month late, 10% for the second month late and so on. The rate will be restored effective on the date the Cost Report is filed.

(b) If a Provider has not filed its Cost Report by six months after the due date, the Division will notify the Provider thirty days in advance that it may terminate the Provider's rates for current services. The Division will rescind termination on the date that the Provider files the required report.

6.08 Special Provisions

(1) Rate Filings. The Division will file certified rates of payment for Nursing Facilities with the Secretary of the Commonwealth.

(2) Appeals. A Provider may file an appeal at the Division of Administrative Law Appeals of any rate established pursuant to 114.2 CMR 6.00 within 30 calendar days after the Division files the rate with the State Secretary. The Division may amend a rate or request additional information from the Provider even if the Provider has filed a pending appeal.

(3) Information Bulletins. The Division may issue administrative information bulletins to clarify provisions of 114.2 CMR 6.00 which shall be deemed to be incorporated in the provisions of 114.2 CMR 6.00. The Division will file the bulletins with the State Secretary, distribute copies to Providers, and make the bulletins accessible to the public at the Division's offices during regular business hours.

(4) Severability. The provisions of 114.2 CMR 6.00 are severable. If any provision of 114.2 CMR 6.00 or the application of any provision of 114.2 CMR 6.00 is held invalid or unconstitutional, such provision will